

DOAS SAP Concept Paper: Coordination – From Beginning to End

People with many or complex needs, as mentioned in the *White Paper, Our health, our care, our say: a new direction for community services, Chapter 5, - Support for people with longer-term needs, January 2006* will be supported by a developing Common Assessment Framework for Adults based on the Single Assessment Process, with close links to Long Term Conditions, the Care Programme Approach, Supporting People and Valuing People.

The emphasis is on empowering individuals with long-term needs to have control and support themselves. Better access to information and integrated health and social care plans will be essential.

It is worth noting the influence that Long Term Conditions and Case Management (with its emphasis on self care/self management) has had in health and it is likely that the ethos and growth of resource allocation to individuals through individualised budgets will have great significance in social care over the next few years (from 'care' to 'support'?).

The White Paper calls for more collaboration between health and social care to create multidisciplinary networks to support those people with the most complex needs and states the importance of investment in training and development of skills for staff that care for people with ongoing needs.

With this background, this paper focuses on the crucial area of support and coordination for individuals and their carer(s) from beginning to end (**please see also DOAS SAP Concept: Beginning and Endings**). The emphasis throughout is on working with individuals to enable them to have more control and to support themselves as much as possible.

Coordination

In daily life, many individuals control and coordinate their health care and social care requirements most of the time; for example, resting when not feeling well. They have their own views about their life and what works for them. The services they receive are universal services e.g. transport, education, etc (although many people are socially excluded even from these). We all get support from others but tend not to think of it in that way. We value our independence, our freedom from others, and we tend to ignore our everyday reliance on others (although for severely disabled people, it is often impossible to do so).

There are times when an individual's needs become more complex, when self-support (and the support of their informal carers) becomes more difficult, and many professionals and/or services become involved. When this happens, the individual requires extra assistance so that the services that support them are provided in a coordinated manner.

Individuals have often felt their right to self determination, choice and control over their own lives diminishes if they are not supported appropriately when this stage is reached. This loss of self esteem and dignity just adds to the difficulties they are experiencing.

A professional's positive attitude and approach to supporting the individual in this situation can make a significant difference. Recognising that each individual has their own unique situation, and a desire to have control over their own life, is key. It is the starting point for how support/care should be provided whilst keeping within statutory (and financial) boundaries.

Continuity of Care and Coordination

From entry into service onwards, there should be a named contact/support who acts as a central point of reference supporting the individual and their carer(s). For many people with single or 'simple' need(s) this will probably be their GP in the first instance. It is when an individual's needs become more complex that a more formal holistic assessment is triggered. These triggers need more definition but for GP's they often happen when there is substantial impact on the individual's functional abilities in daily living.

Care Management or Case Management for people with Long Term Conditions takes place for people with the most complex needs when a formal, proportionate, holistic assessment is indicated and would normally cover all aspects of coordination, including still having a role when the individual is admitted to hospital.

Ideally, the same health and/or social care worker should be supporting the individual throughout the process. Where this is not possible, the aim should be to limit the 'hand offs' or handovers between health and social care workers to a minimum.

There are best practice principles underpinning coordination. These include:

- Recognising that individuals value independence, choice and control
- Maintaining a friendly but professional manner that is neither patronising nor threatening in any way
- Using everyday language - never jargon or professional terms/labels which may not easily be understood by a non professional
- Serving as a source of information and advice from the outset for the individual and their carer(s), promoting health and wellbeing and preventing ill health
- Encouraging the participation of the individual and promoting supported self care/self management to have more control, for example, direct payments and individualised budgets for social care services
- Being the main point of contact when supporting the individual and their carer(s); also to support the individual to obtain advocacy/agent/broker services as appropriate.
- Coordinating the care team to identify and meet the needs of the individual and their carer(s) if the individual is unable to do). Information should be shared to those with a legitimate relationship with the informed consent of the individual.

Best Practice has shown that Coordination under SAP can usefully be broken down into Assessment Coordination tasks and Care Coordination tasks.

Holistic Assessment

The proportionate holistic assessment (often an overview) should be carried and coordinated by a health or social care professional from the discipline best able to meet the most pressing needs of the individual (as indicated by the information available at that time).

The proportionate holistic assessment would identify risks and needs (physical, mental, social, and developmental, etc). This holistic assessment should also identify abilities, strengths and preferences. The individual's perspective, views and self assessment should be encouraged at all times.

Flexibility is to be encouraged because the circumstances of the individual and their carer(s) might change at any time e.g. emergency care might be required during the assessment stage or further assessment(s) may well be required after the care planning stage.

Assessment coordination tasks include,

- Valuing the experience and expertise of individuals and carers; particularly their understanding of their own requirements
- Working together with the individual and their carer(s) to ensure an appropriate, proportionate holistic assessment takes place and with time given for self assessment
- Making sure specialist assessments are completed as necessary
- Ensuring assessment information is collected, evaluated and linked to the summary of risks and needs
- Explaining consent (to share information) to the individual and ensure that her/his wishes are followed within legal guidelines and reviewed
- Ensure that eligibility decisions are made based on the assessed level of need and open, transparent criteria communicated in plain English.

Care Planning – supporting people

The risks and needs identified from the assessment are addressed by joint planning of the care with the individual, their carer(s) and relevant professionals, to achieve agreed outcomes These can then be used to commission the services to support the individual in the personalised integrated care plan (made accessible to the individual in the most user friendly way).

If the summary of risks and needs from the assessment indicates a care coordination role, then the most appropriate care coordinator from health and social care should be identified to oversee the planning and

delivery of care at least until the first review. Continuity of care, the views of the individuals and carers concerned, and their best interests, will be important criteria for this decision.

Regular reviews should take place in consultation with the individual to ensure that the personalised care plan remains relevant, outcomes are being achieved, that changes are not missed and that the individual and their carer(s) are supported appropriately e.g. clear information about their self care/self management when services are no longer required.

Care Coordination tasks include,

- Enabling individuals to give informed consent to share their information, and in particular, their personalised care plan, with the rest of their care team
- Working together with the individual and their carer(s) to ensure that the personalised health and social care plan is implemented
- Monitoring services making sure they are delivered effectively, on time and are achieving their objectives
- Facilitating communication between multiple agencies and professionals and oversee discussion/meetings as appropriate in conjunction with the individual
- Maintaining contact with the individual during periods in hospital and involvement in arrangements for discharge
- Ensuring that reviews are undertaken and documentation updated appropriately.

Conclusion

Many people meet their own lower level health and care needs most of the time, often with the support of their GP. However, there are times when an individual's needs increase, and become more complex. When this happens, the individual requires extra assistance so that the services that support them are provided in a coordinated manner.

A Care Manager/Case Manager works with the individual with complex needs to provide support, continuity and security to co-ordinate their assessment(s), and, when appropriate, their care planning and services, encouraging self determination and supported self care/self management.

The individual and their carer(s) should be participating fully in the process. For this to happen, the individual and their carer(s) must be able to access easy to understand information, from the beginning to the end, and have the expectation of clear and understandable answers to any questions.

Recommendations

- The question as to who can undertake coordination can be examined in light of the recent White Paper's recommendation that, "by 2008 it is expected that all PCT's and local authorities will have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs." There is a necessity for clarification about Care Management/Case Management roles.
- There should be a combined Competency Framework (with the acknowledgement of each disciplines specialist area) maybe using as a basis the Case Management Competencies for Long Term Conditions (linking with Skills for Health and Skills for Care).
- The requirement for a responsible professional/named contact (not necessarily a qualified worker) to support individuals with their lower level needs will also need definition.
- A shift to 'signposting on' in health and social care rather than 'screening out' is essential when eligibility decisions are made.
- Examine how IT enables an individual take control of their own life; including coordinating and managing their own health and social care support. This has implications for HealthSpace. What access will individuals have to their electronic 'case' file in the future– not least their integrated care plan?